CLAIMS FILING DEADLINE

1.0. TIME LIMITATIONS ON FILING TRICARE CLAIMS

1.1. All TRICARE claims shall be stamped with an internal control number (ICN). The actual date of receipt shall be counted as day one. The ICN uniquely identifies each claim, includes the actual date received in the contractor's custody, and permits aging and counting of the claim for workload reporting purposes at specific system locations at any time during its processing. The contractor shall provide procedures to ensure the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied for paperless claims.

1.2. All claims for benefits must be filed with the appropriate TRICARE contractor no later than one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service.

EXAMPLE:

FOR SERVICE OR DISCHARGE	MUST BE RECEIVED BY THE CONTRACTOR
March 22, 2004	No later than March 22, 2005
December 31, 2004	No later than December 31, 2005

1.3. Any written request for benefits, whether or not on a claim form, shall be accepted for determining if the "claim" was filed on a timely basis. However, when other than an approved claim form is first submitted, the provider shall be notified that only an approved TRICARE claim form is acceptable for processing a claim for benefits. The contractor shall inform the provider in writing that in order to be considered for benefits, an approved TRICARE claim form and any additional information (if required) must be submitted and received by the contractor no later than one year from the date of service or date of discharge, or 90 calendar days from the date they were notified by the contractor, whichever is later. The provider should submit claims on either the HCFA Form 1500 or the UB-92, as appropriate.

2.0. EXCEPTIONS TO FILING DEADLINE

2.1. Retroactive Determinations

2.1.1. In order for an exception to be granted based on a retroactive determination, the retroactive determination must have been obtained/issued after the timely filing period elapsed. If a retroactive determination is obtained/issued within one year from the date of service/discharge, the one year timely filing period is still binding.

2.1.2. Only the Uniformed Services or the Department of Veterans Affairs may determine retroactive eligibility. For purposes of granting an exception, retroactive issuance of a Nonavailability Statement for inpatient mental health shall be treated as retroactive eligibility. Once a retroactive eligibility determination is made, an exception to the claims filing deadline shall be granted. A copy of the retroactive eligibility decision must be provided. In any case where a retroactive "preauthorization" determination is made to cover such services as the *Extended Care Health Option (ECHO)*, adjunctive dental care, surgical procedures requiring preauthorization, etc., the timely filing requirements shall be waived back to the effective date of the retroactive authorization. Claims which are past the filing deadline must, however, be filed not more than 180 days after the date of issue of the retroactive determination.

2.2. Administrative Error

2.2.1. If an administrative error is alleged, the contractor shall grant an exception to the claims filing deadline only if there is a basis for belief that the claimant had been prevented from timely filing due to misrepresentation, mistake or other accountable action of an officer or employee of TMA (including TRICARE Overseas) or a contractor, performing functions under TRICARE and acting within the scope of that individual's authority.

2.2.2. The necessary evidence shall include a statement from the claimant, regarding the nature and affect of the error, how he or she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed, as well as one of the following:

- A written report based on agency records (TMA or contractor) describing how the error caused failure to file within the usual time limit, or
- Copies of an agency letter or written notice reflecting the error.

NOTE: The statement of the claimant is not essential if the other evidence establishes that his or her failure to file within the usual time limit resulted from administrative error, and that he or she filed a claim within 90 calendar days after he or she was notified of the error. There must be a clear and direct relationship between the administrative error and the late filing of the claim. If the evidence is in the contractor's own records, the claim file shall be annotated to that effect.

2.3. Inability To Communicate And Mental Incompetency

2.3.1. For purposes of granting an exception to the claims filing deadline, mental incompetency includes the inability to communicate even if the result of a physical disability. A physician's statement, which includes dates, diagnosis(es) and treatment, attesting to the beneficiary's mental incompetency shall accompany each claim submitted. Review each statement for reasonable likelihood that mental incompetency prevented the person from timely filing.

2.3.2. If the failure to timely file was due to the beneficiary's mental incompetency and a legal guardian had not been appointed during the period of time in question, the contractor shall grant an exception to the claims filing deadline based on the required physician's statement. (See above.) If the charges were paid by someone else, i.e., spouse or parent,

request evidence from the spouse or parent that the claim was paid and by whom. When the required evidence is received, make payment to the signer of the claim, with the check made out: "Pay to the order of (spouse's or parent's name) for the use and benefit of (beneficiary's name)."

2.3.3. If a legal guardian was appointed prior to the timely filing deadline and the claims filing deadline was not met, an exception cannot be granted due to mental incompetency of the beneficiary.

2.4. Provider Change From Non-Participating To Participating

A written request for an exception to the claims filing deadline must be submitted by the participating provider only when the claim is changed from nonparticipating to participating. No written request is required on a participating claim.

2.5. Other Health Insurance (OHI)

2.5.1. The contractor may grant exceptions to the claims filing deadline requirements, if the beneficiary submitted a claim to a primary health insurance, i.e., double coverage, and the OHI delayed adjudication past the TRICARE deadline.

2.5.2. These claims must have been originally sent to the OHI prior to the TRICARE filing deadline or must have been filed with a TRICARE contractor prior to the deadline but returned or denied pending processing by the OHI.

2.5.3. The beneficiary must submit with the claim a statement indicating the original date of submission to the OHI, and date of adjudication, together with any relevant correspondence and an Explanation of Benefits or similar statement.

2.5.4. The claim form must be submitted to the contractor within 90 days from the date of the OHI adjudication.

3.0. TIME LIMITATIONS FOR EXCEPTIONS

3.1. There is no time limit stipulated for submitting written requests for exceptions to the claims filing deadline before a claim has been submitted. However, after the proper claim has been submitted and an exception to the claims filing deadline granted, the contractor is authorized to consider for benefits only those services or supplies received during the six years immediately preceding the receipt of the request. Services or supplies claimed for more than six years immediately preceding the receipt of the request shall be denied.

3.2. If a contractor receives a request for an exception to the filing deadline, but a completed claim form is not enclosed, the contractor shall:

- Inform the claimant of the requirement that an approved TRICARE claim form must be completed and submitted before benefits may be considered,

- Advise the claimant that the claim and supporting documentation must be resubmitted within 90 calendar days from the date of the contractor's letter, and

- Provide the beneficiary with appropriate forms.